DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504002	A. BUILDING _____ B. WING _____	07/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BHC FAIRFAX HOSPITAL	10200 NE 132ND ST, KIRKLAND, WA, 98034

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
0000	Initial Comments 33900 MEDICARE COMPLAINT INVESTIGATION The Washington State Department of Health (DOH) in accordance with Medicare Conditions of Participation for Acute Care Hospitals set forth in 42 CFR 482 conducted this health and safety survey. Onsite dates: 07/23/18 to 07/27/18 Intake number: 83163 The survey was conducted by Surveyor #3 Surveyor #6 DOH staff found the facility NOT IN COMPLIANCE with the following Conditions of Participation: 42 CFR 482.13 Patient Rights .

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A0115	Patient Rights 482.13 Corrected On: 08/31/2018 33900 . Based on observation, interview, and document review, the hospital failed to provide for patient safety and protection of patient rights. Failure to protect and promote each patient's rights risks patients suffering physiological or psychological harm. Findings included: Failure to provide contact information for filing a grievance with the State agency. Failure to resolve grievances in a timely manner. Failure to delegate the responsibility for review and resolution of grievances to a grievance committee. Failure to implement a system that provided a safe environment for those identified as high risk for suicide. Failure for licensed providers to write an appropriate order for each seclusion/restraint episode Due to the severity of the deficiency under 42 CFR 482.13, the Condition of Participation for Patient

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	Rights was NOT MET. Cross Reference: Tags A0118, A0119, A0144 .
A0118	Patient Rights: Grievances 482.13(a)(2) Corrected On: 09/13/2018 37242 . Item 1 - Contact information for filing a grievance with the State agency Based on interview and document review, the hospital failed to provide patients or patient representatives with information for lodging a grievance with the State agency (Department of Health) that has licensure survey responsibility for the hospital. Failure to inform patients of their rights to file a grievance with the State places patients at risk of harm related to inability to address their concerns. Findings included: 1. On 07/26/18 at 1:00 PM, Surveyor #6 interviewed the Risk Management Coordinator (Staff #602) about the patient's grievance process and information to access the State complaint process. Staff #602 stated the appropriate telephone number and contact information is provided on the Voluntary Patient's Rights form #092 and the Involuntary Patient's Rights form #093. Every patient signs one of those

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forms and keeps a copy. Document review of the hospital's policy titled, "Patient Rights and Responsibilities," policy #1800.1, effective 07/17, showed that information to access the State complaint process is not included.

At the time of the interview, Surveyor #6 asked Staff #602 to identify where on the posted patient rights signage, the telephone number for the State Complaint process was located. Staff #602 confirmed the information was not there.

2. Document review of the hospital's form titled, "Voluntary Patient's Rights," form #092, revised 03/11, showed that information to access the State complaint process is not included.

Document review of the hospital's form titled, "Involuntary Patient's Rights," form #093, revised 03/11, showed that information to access the State complaint process is not included.

Item 2 - Grievances resolved in a timely manner

Based on interview and document review, the hospital failed to adhere to its policy for resolution of patient grievances.

Failure to resolve patient grievances risks incomplete and unresolved grievances thereby affecting quality care for all patients.

Findings included:

1. Document review of the hospital's policy titled, "Patient Complaints and Grievances," policy # PI-

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004, revised 11/17, showed that staff who receive a complaint or grievance should ask the patient or patient representative to complete the Patient Grievance Form; document receipt of the form; and forward the form to the Patient Advocate for documentation and follow-up.

2. On 07/23/18 at 11:30 AM, during patient record review on the North Unit, Surveyor #3 observed Patient Grievance Forms in the file for Patient #1. The observation showed that the forms did not confirm documentation of receipt or any indication they had been forwarded to the Patient Advocate. Patient #1 had entered a grievance date of 07/20/18.

3. On 07/26/18 at 1:00 PM, Surveyor #6 reviewed a grievance log for 2018. All grievances included on the log are listed as complete. Patient #1's grievance was not included in the log.

4. On 07/27/18 at 9:30 AM, Surveyor #6 interviewed the Patient Advocate (Staff #606) about the Patient Grievance Process and the grievance log for 2018. Staff #606 stated that only completed (resolved) grievances are logged, and that grievances undergoing investigation are date and time stamped when they are received in the Patient Advocate's office. Staff #606 stated that the Patient Advocate's office had not received a copy of the Patient Grievance Form from Patient #1.

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A0119

Patient Rights: Review Of Grievances
482.13(a)(2)
Corrected On: 08/30/2018

37242

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Based on document review and interview, the hospital's Governing Body failed to review and resolve grievances or delegate responsibility for review and resolution of grievances to a grievance committee.

Failure to review and resolve grievances, or delegate the responsibility for review and resolution of grievances risks inadequate evaluation of all aspects of the grievance process.

Findings included:

1. Document review of the hospital's Governing Body Bylaws, adopted 01/01/11, showed that the governing body is accountable for the safety and quality of care, treatment, and services of the hospital. There is no indication that the Governing Body delegated responsibility for review and resolution of grievances to a grievance committee.

Document review of the hospital's policy titled, "Patient Complaints and Grievances," policy # PI-004, revised 11/17, showed that staff should forward Patient Grievance Forms to the Patient Advocate for follow-up. The Patient Advocate will investigate the grievance, record findings, resolve the grievance, inform the patient or patient representative, and provide the patient or patient representative a

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written letter of resolution.

2. On 07/26/18 at 1:00 PM, Surveyor #6 interviewed the Risk Management Coordinator (Staff #602) about the patient's grievance process. Staff #602 stated that the Patient Advocate (Staff #606) investigates and resolves all patient grievances.

3. On 07/27/18 at 9:00 AM, Surveyor #6 interviewed the Patient Advocate (Staff #606) about the patient grievance process. Staff #606 stated that grievances are resolved within 7 days of receipt. Resolution includes a written response to the patient or patient representative. A member of the Executive Team pre-approves the written responses. Staff #606 stated that the hospital does not have a Grievance Committee, and that the Quality Council reviews grievance trends quarterly.

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A0144

Patient Rights: Care In Safe Setting
482.13(c)(2)
Corrected On:

33900

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Based on observation, interviews, record reviews and review of hospital policies and procedures, the hospital failed to implement a system that provided a safe environment for those identified as high risk for suicide.

Failure to ensure a safe environment places patients at risk for serious injury or death.

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Findings included:

1. Document review of the hospital's policy and procedure titled, "Suicide Precautions," policy number 1000.24, last revised 05/18, showed that staff would observe patients on suicide precautions with an increased level of vigilance. Room searches are conducted daily or more often as indicated to remove harmful or contraband items.

2. On 07/24/18 at 10:30 AM, Surveyor #3 interviewed a registered nurse (Staff #304) working on the child and adolescent unit about levels of observational monitoring. Staff #304 stated the unit had three patients (Patient #307, #308, #312) at the beginning of shift on every 5-minute monitoring but currently only Patient #307 and #308 were on every 5-minute checks . Both patients had recently demonstrated suicide gestures that involved wrapping materials around their neck.

3. On 07/24/18 at 11:00 AM, Surveyor #3 inspected Patient #307's room (Room #406). The surveyor observed a towel and scrub bottom pant lying on a desk near Patient #307's bed. The surveyor also observed a pillowcase and blanket lying on top of the other unoccupied bed in the room.

4. On 07/24/18 at 11:10 AM, Surveyor #3 interviewed the registered nurse (Staff #304) about the surveyor's observations of the towel and other items being available in the room. Staff #304 stated she was unaware of this and the items should not be in the room.

5. On 07/24/18 at 11:30 AM, Surveyor #3 reviewed the

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medical record of Patient #307 who was admitted on 07/17/18 from the partial hospitalization program for suicidal thoughts with a plan and psychosis. The review showed the following:

- An admission psychiatric evaluation indicated that Patient #307 was having auditory hallucinations with an imaginary friend telling her to hurt herself. The provider's impression was that she is at high risk for suicidal behavior.

- On 07/23/18 at 8:20 PM, a progress note showed a registered nurse entered Patient #307's room to check in on her condition because of other patients concerns for her increasing anxiety. The nurse observed Patient #307 talking to her roommate and then proceeded to tie a blanket with a knot around her neck loosely. The nurse was able to talk with the patient and remove the blanket from her possession. Patient #307 stated, "You're ruining my plan". Patient #307 was placed in a suicide gown with suicide linens. The patient received additional medications and was placed on every 5-minute observational monitoring.

6. On 07/24/18 at 1:15 PM, Surveyor #3 reviewed the medical record of Patient #312 who was admitted on 07/17/18 from the partial hospitalization program for increasing thoughts of suicide ideation. The review showed the following:

- The patient had previously been admitted on 07/01/18 for suicide attempt by drug overdose and was discharged on 07/13/18. The patient began the partial hospitalization program on 07/16/18.

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-Admission orders on 07/17/18 at 12:45 PM showed the patient was ordered for every 15-minute observational monitoring and suicide precautions.

- On 07/18/18 at 2:23 PM, a daily nursing progress note showed Patient #312 gave a previously hidden shoelace to a program specialist (mental health technician) but denied any intent or plan to use it. The patient contracted for safety at the time of discovery.

- Physician orders dated 07/19/18 at 10:18 AM showed unit restrictions and suicide precautions discontinued.

- On 07/22/18 at 6:25 PM, a daily nursing progress note showed the patient was found making a noose out of shoe strings in his bathroom at the beginning of the shift. The patient was placed on room lockout and ordered for every 5-minute observational monitoring. Additionally, the patient was placed back on suicide precautions.

-A daily progress note dated 07/23/18 at 12:22 AM (late entry) showed that on 07/22/18 at 3:45 PM, the patient was discovered in his room with a shoelace tied into a loop at one end and tied to a grate in the ceiling of his bathroom. The patient was standing on a chair and had told other patients that he was going into his bathroom to "do something". The patient was placed on increased observations and locked out of room for the remainder of the shift. A skin and patient belongings search were performed with no additional contraband found.

7. On 07/24/18 at 1:15 PM, Surveyor #3 reviewed the

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medical record of Patient #308 who was admitted on 07/01/18 after attempting to jump off a bridge. The review showed the following:

-The admission High Risk Notification Alert was marked for suicidal and self-harm indicators.

- On 07/23/18, the patient's condition had improved and was taken off suicide precautions and was on 15-minute observational monitoring checks.

- A progress note on 07/23/18 at 4:30 PM showed Patient #308 approach staff to discuss his anxiety. Patient was escorted to an area of reduced stimuli to discuss his feelings. After completing the discussion, the patient returned to his room. Shortly, afterwards, a registered nurse went back to check on the patient. The patient was found in the bathroom with a piece of torn towel and stated, "I can't do this anymore".

Attempts to verbally de-escalate the situation were unsuccessful. The patient was observed holding the towel in his hands around his neck pulling it tightly without knotting it. The nurse responded by placing their hand between the towel and his neck to ensure an open airway before it could be removed. While holding the towel, the patient displayed facial discoloration. The patient was placed back on suicide precautions, unit restriction, and placed on every 5-minute observational monitoring. Enhanced vital signs, neuro checks, and pulse oximetry checks were ordered. A medical consultation to evaluate the patient was also ordered.

- A case management progress note on 07/24/18 at

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10:38 AM showed the case manager (CM) met with the patient one-on-one to check in on his suicide attempt from the previous night. The patient told the CM, he hallucinated about rats. He did not remember what happen but his roommate had told him he was on top of his desk stating "Kevin wins". The progress note showed the patient went into the bathroom and tied a towel around his neck. The nurse wrestled with the patient and the towel and was able to de-escalate the situation. The CM noted the patient had bruising on his neck and face.

8. On 07/24/18 at 1:50 PM, Surveyor #3 interviewed a program specialist (mental health technician) (Staff #305) about a behavioral "code" called on the unit earlier involving Patient #308. Staff #305 stated she had tried to get Patient #308 to turn in some pencils that he had used during the case management group. After refusing to return them, Patient #308 then attempted to barricade the door and Staff #305 had to get the assistance of other staff to open the door. After a brief period of de-escalating the situation, Patient #308 became agitated. The patient then grabbed a towel, tore it, and went into the bathroom wrapping it around his neck before staff could intervene. When asked how the patient could access a towel so easily, she stated it was difficult to control those items when other patients are sleeping in the same room.

- At the time of the incident, the Child and Adolescent South Unit electronic intake census board showed (under the notes section) that Patient #308 could have two pillows per physician order but no towels were allowed in the room.

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9. On 07/25/18 at 2:25 PM, Surveyor #3 interviewed a registered nurse (Staff #304) about staffing and the suicide attempt of Patient #308. Staff #304 stated staffing could be better. The unit should have as much staff as possible. The nurse stated the child and adolescent unit deals with some very depressed and psychotic kids. Generally, she feels the unit is staffed safety but yesterday was unsafe.

10. On 07/25/18 at 3:45 PM, Surveyor #3 reviewed the medical record of Patient #308 surrounding the strangulation attempt on 07/25/18. The review showed the following:

-A psychiatrist progress note dated 07/24/18 at 3:00 PM showed Patient #308 attempted to strangle self with towel. A code was called and the registered nurse had to cut off the towel. The patient was on every 5-minute monitoring at the time of the suicide attempt. The patient's monitoring status was changed to one-to-one direct monitoring after the event.

-A seclusion/restraint note dated 07/24/18 showed that the patient went into the bathroom and staff followed. Hospital staff saw that Patient #308 had torn his flannel shirt and had placed part of the towel around his neck. Staff cut the towel off the patient, took the flannel pieces of the shirt away from the patient. The patient was placed in a physical hold restraint from 1:50 PM to 2:03 PM to prevent him from continuing to grab towel pieces to hurt himself.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504002	A. BUILDING _____ B. WING _____	07/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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A0168	Patient Rights: Restraint Or Seclusion 482.13(e)(5) Corrected On: 09/13/2018 33900 . Based on record review, interview, and review of hospital policies and procedures, the hospital failed to ensure that a licensed provider wrote an order for seclusion or restraint for 2 of 4 seclusion records reviewed (Patient #305, #306). Failure to ensure that a provider writes an appropriate order for seclusion risks psychological harm, loss of dignity, and personal freedom. Findings included: 1. Document review of the hospital's policy and procedure titled, "Seclusion / Restraint / Physical Hold," policy number 1000.53, last revised 05/18, showed that the physician or registered nurse assesses the need for restrictive intervention. A written or telephone order is obtained from the physician for the seclusion or restraint episode. For adults, 18 years and older, the seclusion/restraint episode may be written for up to four hours. For youth, ages 9 to 17, the seclusion/restraint episode may be written for up to two hours.

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2. On 07/26/18 at 11:50 AM, Surveyor #3 reviewed the medical records of four patients who were placed in seclusion during their hospitalization. The review showed:

a. Patient #305 was a 25 year old who was placed in seclusion after striking a hospital staff member. No physician order for seclusion was found in the medical record.

b. Patient #306 was a 15 year old who was placed in seclusion after kicking a hospital staff member. A physician order for seclusion was written for a four-hour period instead of the maximum 2-hour time interval allowed in the hospital policy.

3. An interview at the time of the review with the Hospital Risk Manager (Staff #303) confirmed the finding.

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A0315

Providing Adequate Resources
482.21(e)(4)
Corrected On: 09/13/2018

37242

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Based on observation and interview, the hospital failed to have an effective quality control process to ensure that patient care supplies did not exceed their manufacturer's expiration date.

Failure to ensure patient care supplies do not

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exceed manufacturer's expiration date places patients at risk for inadequate medical treatment and exposure to infectious organisms.

Findings included:

1. On 07/23/18 at 2:30 PM, Surveyor #6 inspected the housekeeping cart in use by a housekeeper (Staff #605). The observation showed that the dispenser of Dispatch wipes (used to disinfect patient mattresses) had a manufacturer's expiration date of 08/17.

At the time of the observation, the Risk Management Coordinator (Staff #602) confirmed the expiration date and discarded the disinfectant wipes.

2. On 07/24/18 at 9:15 AM, Surveyor #6 inspected the Exam/Consult room on the W-2 Unit. The observation showed that the following patient care items had exceeded their manufacturer's expiration date:

a. Approximately 40 Triple Antibiotic 0.3-gram packets - expiration date 04/18;

b. Approximately 50 Tegaderm Film (a transparent wound dressing) - expiration date 06/18;

c. 2-pair Triflex sterile exam gloves - expiration date 02/15.

At the time of the observation, Staff #602 confirmed the expiration dates and discarded the items.

3. On 07/24/18 at 10:25 AM, Surveyor #6 inspected the Exam/Consult room on the W-1 Unit. The

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observation showed that a dispenser of PDI Sani-Cloth Bleach Wipes had a manufacturer's expiration date of 01/18.

At the time of the observation, Staff #602 confirmed the expiration date and discarded the disinfectant wipes.

4. On 07/25/18 at 9:25 AM during an inspection of the West Two unit, Surveyor #3 found the following:

a. Two blue-topped laboratory tubes with an expiration date of 07/31/17.

b. Two red-topped laboratory tubes with an expiration date of 08/31/17.

c. Two golden-topped laboratory tubes with an expiration date of 04/30/18.

d. Thirty-eight packages of "Tegaderm" transparent film with an expiration date of 06/18.

e. Fourteen packages of filament reinforced ski closure strips with an expiration date of 07/17.

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